



R Goals of Care Designations during Pandemic Conditions: Ethical Considerations

Note: The circumstances surrounding the COVID-19 pandemic are changing rapidly. The ethical considerations outlined in this document are intended to support decision-making in response. The direction provided in this document is intended for teams who are NOT involved in formal triage processes for access to critical care resources.

Introduction

Decisions about Goals of Care Designations (GCD) and, specifically, whether resuscitative interventions should be provided, should be made jointly following discussion between a patient (and/or their appropriate substitute decision-maker) and the clinical team. The GCD should reflect a shared understanding of the available, appropriate medical options and the patient's deeply-held values, wishes, and beliefs. Where consensus cannot be reached between the patient and the clinical team, usual practice is to follow the dispute resolution mechanism in the Alberta Health Services (AHS) [Advance Care Planning/Goals of Care Designation](#) procedure. Following existing procedure helps ensure consistency across patient populations and respects the procedural values underlying that document, such as broad stakeholder engagement and consultation.

A pandemic changes a number of usual features of the health care context. These changes may cause health care providers to have questions about following standard practice. For instance, patient interactions including resuscitation may pose a greater risk to care providers, there may be concerns about access to appropriate personal protective equipment (PPE), fears about infecting health care providers and other patients, and anticipated scarcities in resources such as ICU beds and ventilators. During a pandemic, there may be limited time and personnel to follow the dispute resolution mechanism described in the [Advance Care Planning/Goals of Care Designation](#) procedure.

This document outlines ethical considerations that are relevant to questions that may arise about GCDs, especially as they relate to resuscitative interventions during this pandemic context. The responses should not be considered legal advice, and legal counsel should be sought where appropriate.

As this pandemic evolves, ethical judgments about which actions are justified may evolve as well. While it is important to anticipate and plan for future circumstances, it is equally important not to prematurely implement changes in usual processes that are not yet required or that do not reflect the current health care reality. **Adjustments in process should only be implemented following direction from AHS leadership** (www.ahs.ca/covid). Temporary processes adopted to reflect a new reality should also be reviewed and revised when circumstances change.

Values that ought to be considered during decision-making include:

- Promoting public good (i.e. saving as many lives as possible)
- Respecting patient autonomy, upholding patient values, wishes and beliefs, and allowing patients to be involved in decision-making to the extent possible
- Balancing patient harm with anticipated benefits
- Upholding our duty of care (non-abandonment of the patient)
- Protecting health care providers
- Treating people and groups fairly by treating morally relevant cases alike, and by ensuring fair and equitable access to resources and opportunities
- Promoting trust with patients, family members and the public
- Using limited health care resources responsibly in a way that enables the system to meet the needs of all as best as possible

With any complex ethical issue, there may be values that conflict – that is, they cannot all be lived up to at the same time. In order to resolve the conflict, values must be prioritized to determine which are the most important in the context; alternately, strategies to resolve the values conflict might be sought. An ethically justified decision is one which aligns with the most important values relevant to the circumstance.

Choosing between competing values can be distressing as it necessarily means that we are unable to live up to one or more important values. In conditions of scarcity, it may be necessary to triage patient access to care, which could potentially result in some patients receiving different interventions than they would under non-pandemic conditions. While these choices may be ethically justified, it does not mean they are easy. AHS has several [resources](#) available to provide support for AHS employees.

Questions

1. Do health care providers have a duty to provide cardiopulmonary resuscitation during a pandemic if they do not have the appropriate personal protective equipment (PPE)?

No. Health care providers are not obligated to provide CPR if they do not have appropriate PPE. As always, the individual care provider should determine what PPE is required through their [point of care risk assessment](#).

Note: For current information about PPE, see www.ahs.ca/covidppe.

It is important to respect patient wishes and to provide appropriate, beneficial medical interventions to patients, as reflected in their GCD order. It is also important to protect health care providers from exposure and to provide safe working environments. Infection of a health care provider is a harm in and of itself. In a pandemic, health care providers becoming infected presents further harms by potentially exposing vulnerable patients to risk. It also reduces the number of trained staff available to care for others. After weighing these values, protecting health care providers and promoting the public good justifies not providing resuscitation when appropriate PPE is not available (see [Joint Agreement on use of PPE](#)).

However, ways to minimize or reduce this conflict in values should be sought where possible. For example, can the required PPE be obtained? Can responses to codes be organized in a way that would allow smaller numbers of staff to respond, with dedicated PPE, thus both ensuring protection and minimizing exposure of staff members? It may also be possible to adjust resuscitative practices to further minimize risk; consult your clinical and medical leads about how this might be done.

2. Is it permissible to unilaterally change a patient's R GCD if the health care team feels that the designation is inappropriate?

No. Any changes in a patient's GCD should be made in conversation with the patient and/or their substitute decision-maker. This conversation should include all relevant information, including any pandemic-related changes in processes and resource constraints that might affect decision-making.

GCDs are medical orders determined jointly between the patient (and/or their substitute decision-maker) and the clinical team. Changing a GCD unilaterally would demonstrate a lack of respect for the patient's values, wishes, and preferences, and their key role in health care decision-making. It may also serve to undermine trust in the clinical team. Where there is concern about a patient's existing GCD, conversations should be held with the patient (and/or their appropriate substitute decision-maker) and the clinical team. This discussion should include all of the relevant facts about the patient's clinical status, available and appropriate medical interventions, and which GCD seems to best fit with the patient's values, wishes and beliefs. If agreement about an appropriate GCD cannot

be achieved, the dispute resolution mechanism detailed in the [Advance Care Planning/Goals of Care Designation](#) procedure should be followed. If a pandemic context does not make pursuing this dispute mechanism feasible, the existing GCD should remain. An R-designation does not compel health care providers to provide resuscitation to individuals for whom resuscitation is felt to be clinically ineffective (*see question 3 below*).

Having conversations with all patients (and/or their substitute decision-makers) who are thought to have ‘inappropriate’ (or overly aggressive) GCDs in the midst of a pandemic may convey a message that the health system intends to abandon these patients. This approach may engender a sense of distrust in patients and family members. Such conversations should be held with sensitivity and thought given to timing; for example, conversations might be sought proactively for patients whose GCDs are felt to be the most clearly inappropriate. For all others, these conversations should occur when patients experience a significant change in their health status or where relevant new health information becomes available. A change in health status continues to be a prompt to initiate a review of GCDs. The discussion can then focus on the patient’s most current clinical information, including the likelihood of a successful resuscitation. The discussion should also include any pandemic-related changes in processes and resource constraints that might affect decision-making. Clear communication of these process changes may help to engender and maintain trust. See the following resources for COVID-19-specific GCD guidance: [Vital Talk Tips](#); [GCD algorithm](#); [Planning Ahead with Vulnerable Patients](#).

3. Is it reasonable to withhold resuscitation from patients with R designations for whom we feel that the GCD designation is inappropriate?

It depends. It is permissible to withhold resuscitation for a patient if the clinical team determines that the patient will almost certainly not benefit from the intervention. On the other hand, it is NOT permissible to withhold resuscitation based on the clinical team’s opinion that the intervention will not be “worth it” for the patient in terms of resulting quality of life.

Providing resuscitation to any patient with an R GCD (whether they are positive for COVID-19 or not) for whom resuscitation has little or no likelihood of success causes harm to the patient without an overriding benefit. This decision is a matter of clinical judgment and should be made by the responding clinical team in light of the particular patient’s current clinical situation. Health care providers have no obligation to provide resuscitation where the patient almost certainly will not benefit from those interventions.

Caution must be exercised in distinguishing between lack of clinical success and the value judgement concerning whether the intervention is “worth it”, i.e. whether the resulting quality of life would be considered valuable. The values, wishes and beliefs of the patient should be given significant weight in determining whether their quality of life after a successful resuscitation would justify the intervention.

During a pandemic, clinical teams should be careful to not make treatment decisions based on assumptions about access to necessary follow-up care, such as admission to ICU. Resource allocation decisions should not be made at the bedside, nor should patients be pre-emptively excluded from possible access to follow-up care. **Pandemic-related limits on interventions should only be set if there has been clear direction from AHS leadership** (www.ahs.ca/covid). If a clinical team is unsure about the availability of future medical care and are unable to seek clarification, they should make the decision which most respects the patient's wishes, as reflected in their GCD order. For a patient with an R GCD, this would include providing the relevant resuscitative interventions and pursuing the necessary follow-up care.

4. Would it ever be justifiable to withhold resuscitation from patients with an R GCD during a pandemic, even if the resuscitation might have a reasonable chance of being successful?

Not likely. Unless a team has received clear and specific direction from AHS leadership about the lack of availability of necessary care following resuscitation, they should proceed as though the patient has a chance of getting access to such care. It would only be justified to withhold resuscitation from a patient with a reasonable chance of benefit if it is confirmed that necessary follow-up care for that particular patient is not available.

There may come a time during a pandemic where necessary care following resuscitation (such as transfer and admission to an ICU) is not possible. Providing invasive interventions and then having the patient be unable to be transferred or admitted to an ICU would be distressing for patients, family members, and health care providers. It would also minimize the benefits that might have outweighed the harms of providing the resuscitation. However, it may be that information about access to follow-up care is unavailable to inform decision-making at the point of resuscitation, other than in exceptional circumstances where clear direction has been provided by AHS leadership.

Decisions about who will be allocated scarce critical care resources **should not be made at the bedside** by frontline clinical teams. These decisions should be made at a higher level by those who are aware of all the relevant information that will influence the decision, such as current ICU bed capacity and competing patient demands. Excluding patients from normally available clinical options pre-emptively, and from outside a centralized triage process, risks inequitable patient access to interventions and opportunities for recovery. **Unless clinical teams receive clear directives from AHS leadership, clinical teams should assume their patients will be considered for access to post-resuscitative care and should proceed accordingly.** Treating all patients equitably will help to maintain trust in the health care system, and with patients and family members.

The possible lack of ICU access and follow-up care after a resuscitation is an appropriate prompt to review any R GCD order with a patient (and/or their substitute decision-maker) during a pandemic. This information is relevant to all GCD discussions since, when critical care capacity is exceeded and a triage protocol is in place, all patients requiring ICU care will be triaged according to the same criteria.

Communicating this information sensitively and clearly helps to preserve trust with patients and families, and enables them to make informed decisions based on clearer expectations about what interventions and resources might be available.

5. *Is it permissible to withhold resuscitation from a particular population of patients based on diagnosis alone?*

No. Clinicians should assess the appropriateness of resuscitation based on the clinical status of the individual patient.

Withholding resuscitation from a patient population solely based on diagnosis does not align with the principle of fairness. There may be relevant differences between patients within a diagnostic group, such as severity of illness and co-morbidities, which may affect an individual patient's likelihood to benefit from resuscitation. Making judgments about access to interventions without first considering the relevant differences within a patient population risks inequitable access to those interventions. Additionally, making these judgments categorically may displace the appropriate use of clinical judgment. This approach may be perceived as unfair and convey the message that some patient groups are "not worth saving". It is disrespectful of patient autonomy within those patient populations and may also damage public trust.

In a public health emergency, public trust will be essential to ensure cooperation with restrictive public health measures. An allocation system should make clear that all individuals are "worth saving" even when it is not possible to save them all. This message can be conveyed by maintaining the eligibility of all patients who would receive critical care during normal conditions, and by allowing a fair and consistently-applied triaging process to determine which patients receive available beds and services during conditions of scarcity.

It is important to note that there are some clinical circumstances that lead to immediate or near-immediate death despite aggressive interventions such that clinicians do not provide critical care services even during normal conditions. **During a public health emergency, clinicians should still make clinical judgments about the appropriateness of interventions using the same criteria they use in normal clinical practice.**

6. *Is it justifiable to withhold resuscitation from a patient who does not meet triaging guidelines for access to ICU?*

No. Clinical teams outside of the centralized triage context should not withhold resuscitation from a patient because they anticipate that the patient would not receive follow-up treatment under a critical care triage protocol.

Withholding resuscitation based on an anticipated lack of follow-up care could result in inequitable access to care. This inequity could be caused by local clinical teams pre-empting the triaging process by making assumptions which do not turn out to be true or are inconsistent with decisions other teams are making. The exceptions to this general rule are if specific directives are communicated by AHS leadership that set categorical limits on access to critical care, or when the clinical team is able to seek direct confirmation that a particular patient would not be able to receive necessary post-resuscitative care.

A central feature of the critical care triage guidelines is that **categorical exclusion criteria are not used to bar individuals from access to critical care services during a pandemic**. There are several ethical justifications for this. First, the use of rigid categorical exclusions would be a significant departure from traditional health care practice and health care ethics, and raise fundamental questions of fairness. Second, such restrictive measures are not necessary to accomplish public health goals during a pandemic; it is possible to assign all patients a priority score and allow the availability of resources to determine which patients receive the scarce resource. Third, categorical exclusion criteria may be interpreted by the public to mean that some groups are “not worth saving,” leading to concerns of unfairness and abandonment, resulting in distrust.

7. Does this pandemic justify revisiting our patients’ GCDs?

Yes. A GCD conversation is always appropriate if there is significant change in the patient’s condition or circumstance, or at the patient or substitute decision-maker’s request.

Given that the pandemic will (temporarily) alter many features of the health system, it could feasibly affect various aspects of a patient’s treatment options, access to services, and prognosis. Accordingly, this change could justifiably prompt a review of the patient’s GCD. It will be important to proceed sensitively in such conversations to avoid conveying the message to patients or family members that patients will be abandoned, which could damage the trust that patients and families have in their clinical teams and the health system.

The pandemic may also spur patients to reflect upon their own goals of care and request a review of their current GCD. Patients may wish to clarify their wishes in anticipation of a possible infection, or their preferences may change in light of their understanding of health system changes during the pandemic. Clinical teams should explore the reasons behind the patient’s request to revisit their GCD and offer information to help minimize any uncertainty or fear. Patients should be reassured that they will not be abandoned and that the team will make every effort to provide the appropriate care, in keeping with the patient’s values, wishes, and beliefs. A shared decision-making model, where the team provides the clinical expertise and the patient (and/or substitute decision-maker) provides the patient’s perspective, can help to engender trust and to determine the most appropriate GCD for the patient in the current pandemic context.

The information in this document is provided to assist health care providers and administrators in considering the ethical implications of complex questions, and should not in any way be construed as legal advice.

For support in working through difficult or complex ethical issues, including those related to COVID-19, please contact the [AHS Clinical Ethics Service](https://www.ahs.ca/clinical-ethics) at 1-855-943-2821 or clinicaethics@ahs.ca.

For **after-hours** assistance with ethics questions related to COVID-19, please call our Rapid Response Clinical Ethics Consultation Service at 1-403-689-3548

